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# Homeless and Mentally Ill: Meeting the Needs

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HOMELESS AND MENTALLY ILL:  
MEETING THE NEEDS

A Thesis

Presented to the  
Department of Sociology  
and the  
Faculty of the Graduate College  
University of Nebraska

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts  
University of Nebraska at Omaha

by  
Donna K. Wilson  
April, 1992

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### THESIS ACCEPTANCE

Acceptance for the faculty of the Graduate College,  
University of Nebraska, in partial fulfillment of the  
requirements for the degree Master of Arts, University of  
Nebraska at Omaha.

#### Committee

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* Mary Ann Korman	Sociology
* Peter T. Swyzka	Public Administration

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4/23/73  
Date

## ABSTRACT

This paper examines the characteristics of homeless mentally ill individuals in a midwest metropolitan area and describes the difficulties they encounter when trying to secure services that would help them change their situation. The study examines the role bureaucracy plays in the social problem of the homeless mentally ill. An ethnographic approach is used to study the question how is it that bureaucracy gets in its own way in attempting to meet the needs of the homeless mentally ill? Both demographic and observational data are provided in this study and the observational data indicate that certain aspects that are inherent to bureaucracy can create barriers to services for individuals who are in need of them.

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## CHAPTER I

## THE HOMELESS MENTALLY ILL: A PROBLEM OF PUBLIC POLICY

"Nationwide, nearly 19 million Americans will be homeless by the year 2003, according to a recent study funded by the Congress and carried out by M.I.T. professor Phillip Clay. Low-income housing advocates believe this estimate is very cautious. New York City's Commission on the year 2000 predicts a shortfall of 372,000 housing units in the city within thirteen years. This estimate, which the commission calls "conservative", tells us that one million family members - one in every seven residents of New York City - will be doubled up or homeless in this century." (Kozol 1988, p.204).

The problem of homelessness in America has been one of growing concern over the last decade. Indeed, there have been homeless individuals among us throughout our history; only the faces have changed. Homeless individuals were once thought to be skid row bums; alcoholic men who clustered in a certain part of town sleeping in alleyways or flophouses. Many of them seemed to prefer living this way. Contemporary homeless individuals do not fit this stereotype. They are men, women, children, young and old. Most of them do not want to be homeless. The contemporary homeless are a very diverse group and so are the reasons for their homelessness. Some are displaced workers, unemployed or underemployed. Others are fleeing abusive situations or may find themselves homeless as a result of some disaster. A few may choose this life-style. For



many, a lack of affordable housing has caused or is perpetuating their homelessness. Moreover, there are those who suffer from psychiatric disabilities. For these individuals, lack of economic resources and affordable housing are not the only issues of concern. These persons need the involvement of other systems of support if they are to improve their situations. It is this group, the homeless mentally ill, that will be the focus of this paper.

This project will describe the interaction between people who are homeless and mentally ill with a bureaucratic service delivery system, with particular attention to needs, services, and intrinsic barriers to those services. This study will examine the characteristics of homeless mentally ill individuals in a Midwest metropolitan area and will describe the difficulties they encounter when trying to secure services that would help them change their situation. Specifically, this project examines the role bureaucracy plays in the social problem of the homeless mentally ill. An ethnographic approach is used to study the question: how is it that bureaucracy gets in its own way in attempting to meet the needs of the homeless mentally ill?

### WHO AND HOW MANY ARE HOMELESS MENTALLY ILL?

To achieve a clear understanding of the problem of the homeless mentally ill, it is necessary to discuss the nature of the problem.

Since homelessness has become an issue of rising concern, studies have been done that attempt to identify who the homeless are and to determine the size of the population. It is important to review some of these studies here to get some sense of the characteristics and needs of the population being studied. However, it is also important to point out that the characteristics of the homeless population may change from region to region. For example, there may be many more Hispanics in the South and West than there are in other regions. Therefore, it is important to know the characteristics of the homeless population in a given geographical area and to avoid generalizing information from studies done in other regions. Also, we must remember that this is a very difficult population to count. Many homeless individuals are not willing to provide information regarding themselves or may not present it factually. Furthermore, many do not frequent shelters and opt instead for abandoned buildings, spaces beneath bridges, or other areas where they are not easily seen or found. For these reasons it is extremely difficult if not impossible to obtain any accurate count of

homeless individuals in any given area (Hope and Young 1986, pp.18-21; Morrissey and Levine 1986, pp.811-812).

Nonetheless, much money and effort has been spent in an attempt to count the number of homeless individuals. For example, the 1990 census included a one-night census of homeless individuals. When one asks why these efforts continue, it becomes apparent that headcounting must serve some function. Unfortunately, much funding is based upon counts of the number of homeless in given areas. For example, the 1990 census numbers will be used in the making of governmental funding decisions on homeless assistance.

According to Hope and Young (1986, pp.18-19) headcounting presents the impression that officials are concerned about the problem and it diverts the attention of policy makers and the public from considering the root causes of the problem. Hope and Young (1986) go on to explain that the numbers are subject to extreme discrepancy as they depend upon the definition of homelessness used, the time of year the count is done, and the authors suspect purpose for which the numbers are given. Due to their highly unreliable nature, this study does not address the question of numbers.

It is difficult to say how many individuals among the homeless are mentally ill as this is an even more difficult population to define and to count. Estimates have ranged

from 10% to 90%. It is likely that different criteria and definitions were used and that other variations in methodology may account for some disparity. Snow, Baker, and Anderson (1986, pp.419-420) also see the medicalization of the homeless problem as a factor that influences the outcome of prevalence studies since the medical profession becomes the source of expertise and they do much of the research.

In comparing definitions of the homeless mentally ill population, Morrison (1989, pp. 952-954) concludes that definitions can be grouped into four categories; 1) admission to a shelter for one night, 2) persons designated as undomiciled in admission records, 3) dichotomous definitions identifying a single homeless mentally ill group, and 4) stratified definitions identifying various homeless mentally ill groups which contain at least three categories. Morrison suggests that "an optimal definition will contain three or more categories and will consider patients' chronicity of homelessness as well as their potential for future residential stability."

A study of homelessness in Minnesota (Minnesota Planning Agency 1988, pp.1-16), pointed out that definition of the problem importantly affects the causes for homelessness and will also reveal differences in population. That is, limited definitions will show a higher

percentage of the chronically homeless. The authors also discuss disagreements of definition among studies; for example, a Vermont study used the "typical" definition of homelessness while an Ohio study used a broader definition and a Chicago study used a more limited definition focusing on the "literally" homeless. The authors point out that the definition of homelessness has policy implications; it determines "what should constitute the floor of housing adequacy below which no member of society should be permitted to fall".

Roth, Bean, and Gerald (1986, pp.712-719) conducted face-to-face interviews with 979 homeless people in 19 counties in Ohio and concluded that the median length of homelessness was 60 days. The causes of homelessness were mostly economic in nature, and there was a 31% rate of mental health hospitalizations among the population. The authors also offer a typology of homeless persons consisting of three different categories: 1) street people, 2) shelter people, and 3) resource people. They also concluded that homelessness is a multidimensional problem.

Morrissey and Levine (1987, pp.811-812) summarized the proceedings of a meeting by NIMH convened July 24-25, 1986 during which researchers discussed latest research findings and examined the needs of homeless mentally ill persons. One of the findings discussed was that "over the past five

years a number of national reports and research studies have confirmed that a significant proportion (30 to 40 percent) of the homeless population suffer from serious and persistent mental illness." Also, researchers reviewed nine of ten research projects that had been completed and found four major areas of agreement in the studies:

- 1) Social heterogeneity of population and multiple needs. Demographic and ecological profiles varied as a function of unique population characteristics of each city and region.
- 2) HMI persons tend to be long-term residents of the areas they are found in but there are few stable residential options available to them.
- 3) A sizeable number of HMI people have been involved with police or have been in jail.
- 4) Most are willing to accept help but their perceptions of needs and service priorities often do not coincide with those of providers.

Sargent (1989, pp.1015-1016) provided another analysis of findings funded by NIMH between 1982 and 1986 to learn more about the relationship between mental illness and homelessness. The basic findings of her analysis were as follows:

- 1) Approximately one third of the homeless population have severe mental illnesses.
- 2) The majority of the population is male, although there is an over-representation of females in the HMI population.
- 3) The median age is 29 to 38 years.
- 4) Blacks and Hispanics are over-represented in the population.
- 5) Only 40 to 50 percent have graduated from high school and most are underemployed.

6) Only one third receive public benefits such as social security although many are eligible.

7) Homeless people in the Midwest and West are more mobile than those in the Northeast.

8) Most homeless people have poor medical health and most of them face threats to themselves and their belongings.

9) Housing and case management top the list of needs of homeless mentally ill persons.

Kroll, Carey, Hagedorn, Firedog, and Benavides (1986, pp.283-286) conducted a survey of 68 homeless adults in eight urban emergency shelters in Hennepin County, Minnesota, using a field tested questionnaire and random sampling of populations in the shelters on one evening. The study indicates that the homeless are predominantly disconnected from social and supportive relationships. There is also under utilization of social services by the homeless population. Other demographic findings were as follows:

- 60 males, 8 females
- 49% under 31 years of age
- 22% 32-40 years of age
- 29% 41-68 years of age
- 60% White
- 19% American Indian
- 18% Black
- 58% never married
- 38% separated or divorced
- 4% currently married
- 41% reported previous or current contact with mental health system
- 6% currently seeing a case manager or social worker for mental health reasons
- 18% reported previous hospitalizations for psychiatric reasons.

### WHY ARE THEY HOMELESS?

In their study of homelessness, the Minnesota Planning Agency (1988, pp.1-16) discussed the issue of responsibility for the problem of homelessness in terms of local v. state v. federal responsibility. In their discussion, two arguments are presented that are thought to determine where responsibility should lie. One argument is that homelessness is a result of social policies and processes that disenfranchise vulnerable people, indicating that economic, social and health policies are the problem. The other argument views homelessness as a result of severe personal deficits, indicating that the individual is the problem.

Tucker (1991, pp.78-88) clearly places the responsibility for the problem of homelessness in the hands of local government. He argues that government regulation such as zoning ordinances are causing homelessness because they have made it impossible to replace single room occupancy (SRO) hotels that have been torn down in urban-renewal efforts.

Lamb and Lamb (1990, pp.301-305) suggest that functional deficits resulting from major mental illness appear to be important contributing factors to homelessness. Included as deficits were such symptoms as disorganized thinking and actions, poor problem-solving



skills, inability to mobilize oneself, depression, and paranoia that prevented acceptance of help. The authors also identified other important factors contributing to homelessness as lack of a comprehensive system of mental health care, substance abuse combined with severe mental illness, and the tendency for chronically and severely mentally ill persons, especially those under 30, to pursue their life goals in an unrealistic or irrational way.

In their discussion of whether or not psychiatric illness is a cause of homelessness, Kellerman, Halper, Hopkins, and Nayowitz (1985, pp.179-188) posit that homelessness and psychiatric illness can be viewed interactionally. That is, mental illness may result in homelessness and homelessness may produce or exacerbate symptoms of mental illness. The authors also state that much of the literature on the prevalence of psychiatric illness among homeless people is based on personal impressions rather than scientific inquiry and is, therefore, unreliable. They suggest that "any discussion that links homeless people and psychiatric illness should be considered within the complex interrelationships between social, economic, and political systems that impact the lives of these individuals".

Changes in mental health policy have had an impact on the lives of the homeless mentally ill. In his discussion

of the policy of deinstitutionalization, Mechanic (1989, p.154) states that "in the last several decades, we have witnessed an enormous social change in the ways in which psychiatric patients are treated and in the contexts of care". He points out that while deinstitutionalization has brought a decline in long-term hospitalizations and has allowed for most of the care and maintenance for mentally ill persons to take place in the community, it has also resulted in some patients actually being worse off. He comments that "community life is no panacea unless the patients' suffering is alleviated and social functioning improved. We have learned that community life, without adequate services and supports, could be as dehumanizing and debilitating as the poor mental hospital". Mechanic also points out that the planning of community services depends upon a firm understanding of the consequences of various policies. Therefore, we must have a thorough understanding of what happens to mentally ill persons outside of the hospital including "the extent to which difficulties occur and the way they are handled". According to Mechanic, "formulation of good public policy requires careful attention to each of the many subgroups that constitute the chronic population". He goes on to say that "policy changes must be evaluated in terms of their

behavioral consequences and problems and not only in terms of administrative statistics".

In discussing the issue of deinstitutionalization, Torrey (1988) cites the definition of deinstitutionalization developed by the Director of the National Institute of Mental Health. It is as follows:

"(1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment, (2) the release to the community of all institutionalized patients who have been given adequate preparation for such a change, and (3) the establishment and maintenance of community support systems for noninstitutionalized people receiving mental health services in the community" (Torrey 1988, p.4).

Torrey goes on to comment that rather than deinstitutionalization, what actually took place was simply depopulation of the state mental hospitals. Torrey (1988, pp.203-204) contends that deinstitutionalization played a crucial role in the cause of the problem of the homeless mentally ill today. Torrey also discusses the effects of the policy of deinstitutionalization and lists eight aspects of the problem:

1. There are at least twice as many seriously mentally ill individuals living on streets and in shelters as there are in public mental hospitals.
2. There are increasing numbers of serious mentally ill individuals in the nation's jails and prisons.
3. Seriously mentally ill individuals are regularly released from hospitals with little or no provision for aftercare or followup treatment.

4. Violent acts perpetrated by untreated mentally ill individuals are increasing in number.

5. Housing and living conditions for mentally ill individuals in the community are grossly inadequate.

6. Community mental health centers, originally funded to provide community care for the mentally ill so these individuals would no longer have to go to state mental hospitals, are almost complete failures.

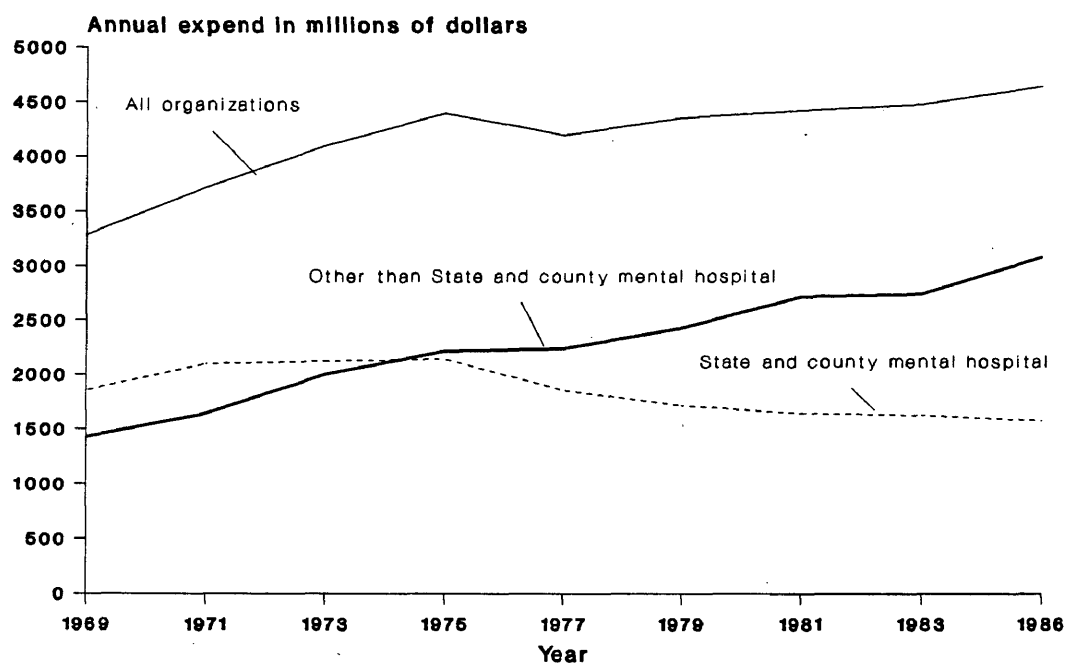
7. Laws designed to protect the rights of the seriously mentally ill primarily protect their right to remain mentally ill.

8. The majority of mentally ill individuals discharged from hospitals have been officially lost. Nobody knows where they are. (Torrey 1988, p.5-6).

At the end of his discussion of the deinstitutionalization policy, Torrey (1988, p.36) concludes that it has been a disaster which resulted from a failed but well intentioned social policy that could be changed if the mistakes that led to the present situation are understood.

Torrey's claim is further supported by the data shown in Figure 1 which indicates that during the years of deinstitutionalization annual expenditures by state and county mental hospitals actually increased slightly and then levelled off to their previous level. There is no indication of any great savings which was to have helped fund Community Mental Health Centers.

Figure 1.



Annual expenditures in constant (1969=100) dollars (in millions), all mental health organizations, State and county mental hospitals and all other organizations: United States, 1969-86.

Source: Manderscheid, R.W. & Sonnenschein, M.A. (Eds.)  
Mental Health United States, 1990  
Washington, D.C.; U.S. Government Printing  
Office, 1990.

Lamb (1984b, pp.899-910) examined the policy of deinstitutionalization and concluded that homelessness among the chronically mentally ill is not the result of deinstitutionalization per se but of the way deinstitutionalization was carried out. Lamb points out that the lack of planning for structured living arrangements and for adequate treatment and rehabilitative services in the community led to unforeseen consequences such as homelessness.

Jones (1983, pp.807-811) traces the history of the homeless mentally ill in the U.S. and discusses the rise of advocacy groups, role of the media, and causes of homelessness. Jones begins with the opening of the first hospital in 1752 and discusses events that led up to the process of deinstitutionalization. Jones views the community support systems that were supposed to be in place for individuals released from institutions as failures and contends that we must be concerned about those who leave institutions with no support systems. Jones sees deinstitutionalization as a major cause of homelessness and lists economic recession, unemployment, cutbacks in federal support programs, and lack of adequate low-cost housing as other causes.

In addressing the issue of deinstitutionalization, Lipton, Nutt and Sabatini (1988, pp.40-45) suggest that the

principles underlying the policy were not wrong; however, comprehensive and integrated resources must exist in the community for it to work. In addition, the authors state that in their view homelessness is less a manifestation of illness than a socioeconomic status arising from gaps and barriers within the health care delivery system.

As a result of a one year study of 49 homeless mentally ill (HMI) patients, Lipton, Nutt and Sabatini (1988, pp.40-45) recommend that adequate services should include: outreach services, shelter, residential alternatives, financial assistance, health care, hospital services, rehabilitation programs, and case management. The study also indicates that the time immediately following discharge from a hospital is a high risk time and it is critical to provide intensive supportive services to HMI individuals at this time. Furthermore, services must emphasize linkage, meaningfulness, and flexibility. They also suggest that service and treatment plans must be perceived as relevant to their needs and meaningful by patients, thus making them more apt to accept services and comply with treatment plans. Services must also provide clients with a sense of dignity, decency, and security. They "must be malleable enough to accommodate patients functioning at different levels or manifesting different types and degrees of pathology".

Lamb (1984, pp.899-910) recommends that a vast expansion of community housing and services and a revamping of the mental health system is needed to meet the needs of the chronically mentally ill for support and stability. Lamb also points out that it is important to put shelters in proper perspective and view them as a necessary stopgap measure, not as permanent solutions and to recognize that they do not address the basic causes of homelessness. Lamb points out that chronically mentally ill individuals need monitoring by means of aggressive case management because many of them are not able to find and maintain such community resources as housing, stable sources of income, treatment, and rehabilitation. Lamb also recommends a change in commitment laws so that it is easier to commit those who are resistive to treatment but in dire need of it. In another writing, Lamb (1984a, p.72) comments that "If deinstitutionalization has taught us anything, it is that flexibility is all important. We must look objectively at the clinical and survival needs of the patients and meet those needs without being hindered by rigid ideology or a distaste for dependency."

Flynn (1985, pp.189-203) writes that programs for HMI clients need to be flexible and tailored to the unique needs of the population. He also states that programs that separate mental health issues from basic needs are doomed



to failure and the programs must seek out those in need as well as being accessible to target clients. In Flynn's assessment, coordination of services is also essential. He contends that those who are unable to follow the rules and regulations of social service agencies should not be cut from services. Rather, it should be presumed that they cannot comply because of mental health issues and they should not be terminated.

In his analysis of what is needed to address the problems of the homeless mentally ill, Torrey (1990, pp.205-206) recommends a combination of the following:

- "1. The seriously mentally ill must get first priority for public psychiatric services.
2. Psychiatric professionals must be expected to treat individuals with serious mental illnesses.
3. Government responsibility for the seriously mentally ill must be fixed at the state or local level.
4. Housing for the seriously mentally ill must be improved in both quantity and quality.
5. Laws regarding the mentally ill must be amended to insure that those who need treatment can be treated.
6. Research on the causes, treatment and rehabilitation of serious mental illnesses must increase substantially."

All the studies cited in this chapter support two important conclusions. First, that the problems of homelessness and the homeless mentally ill are related, but separate problems. Most homeless persons are not mentally

ill. Mental illness policy cannot address all of the problems posed by homeless persons in the United States.

Second, and of immediate importance for this thesis, mentally ill persons with a wide variety of disorders make up a third or more of the homeless population. Sometimes mental illness precedes homelessness, sometimes homelessness precipitates mental illness. A great variety of disorders affect the mentally ill who are homeless. Because the mentally ill are themselves a diverse, not a homogeneous population, variety and flexibility are essential attributes of programs for the homeless mentally ill.

Although variety and flexibility are crucial attributes, many social service programs lack precisely these qualities. A principle reason for this short coming has to do with the bureaucratic administration of programs and with the characteristics of bureaucratic organizations. The impact of bureaucracy on the system of services forms the central problem of the chapter that follows.

## CHAPTER II

### BUREAUCRACY AND THE SERVICE SYSTEM

For those individuals who are not only homeless but also mentally ill, negotiating the complex bureaucratic service system can become an insurmountable task. Furthermore, the rules and regulations of the various agencies sometimes make failure built-in.

Fabricant (1988) writes that rigid intake criteria, excessive documentation demands, categoric definitions of service, cold, impersonal and on occasion hostile responses to expressions of need characterize the interaction of homeless individuals with a highly bureaucratic system. He also comments that categoric definitions of service do not meet the needs of the heterogenic group that comprise the homeless population. Max Weber characterized bureaucracy as being an inflexible system, yet, it is flexibility that is needed to meet the needs of this population.

It could also be argued from another theoretical perspective that homelessness is meant to be because the capitalist system requires that a certain number of disposable poor be kept in the ranks. Belcher and Singer (1988) argue that capitalism enhances the accumulation of resources by intentionally limiting access to social resources by nonproductive citizens, so homelessness will

likely increase unless corporate America is held responsible. This perspective is further supported by an analysis of the War on Poverty done by Michael Katz (1989, pp.91-93). Katz argues that the War on Poverty was plagued by internal contradictions, especially "the translation of a structural analysis of poverty into a service-based strategy". For example, Katz points out that an analyses of poverty stressed its roots in unemployment, yet planners avoided programs that created jobs because it is cheaper to prepare people for jobs than to create jobs for people.

#### BUREAUCRACY AND SERVICE DELIVERY

Bureaucracy is central to the problem of the homeless mentally ill and the barriers they face in attempting to secure the services they need. Bureaucratic administration is based upon formal rules, calculable efficiency, and specialized technical knowledge. As a society, we depend upon bureaucracy to ensure that services are delivered fairly, in the most efficient manner possible, and with calculable results.

Organizations are held accountable for decisions they make such as spending of resources, who is denied or approved for services, what services they receive, and how they are provided. It is expected that these decisions are based upon some scientific or expert knowledge and are not made in an arbitrary fashion. There is supposedly no

room for values or any sense of brotherly love to enter into the bureaucratic decision making process because such personal feelings are irrational. It is within this bureaucratic context that service delivery systems operate.

In his discussion of the aspects of bureaucratic administration, Brubaker (1984, p.20) writes that the specific means of bureaucratic administration is the use of formal, abstract, and general rules. These rules are often found stated in the form of policies or regulations. The policy-making process in the United States usually begins with Congress who produces statutes which reflect decisions regarding a plan of action in response to an identified problem. These decisions must then be implemented by agencies and individuals. To carry out the purpose of the legislation, agencies must interpret the legislation, acquire resources, write regulations and deliver services (Ripley and Franklin 1984, p.3).

Most of the rules and regulations established with regard to service delivery systems are made to allow for accountability and to prevent impermissible outcomes. However, rules are often ambiguous and vague allowing room for interpretation and decision-making based on either wider or narrower interpretation of the rule by the individual enforcing the rule. On the other hand, workers are held accountable for their decisions and could get in

trouble if they allow services to someone who is ineligible. Hence, workers tend to focus on what is measurable or verifiable whenever possible. For example, the use of rules is more complicated in the disability program managed by the Social Security Administration because the definition of a disabled person is rather ambiguous. In order to control for the ambiguity all claims are taken in writing and reviewed by examiners to protect against impermissible outcomes (Wilson 1989, pp. 336-337). The result of this for clients is that the processing of their claim takes several weeks if not months.

Related to this, Wilson (1989, p.149) writes that:

"In government agencies professionals occupy an anomalous position. On the one hand, many professionals are hired because they bring esoteric knowledge to their tasks - they know how to do things that must be done that others cannot easily be taught - and because they are expected to regulate their own behavior on the basis of professional norms. On the other hand, democratic government requires bureaucratic accountability, and that means that no one wholly can be trusted to make important choices free of legal and administrative constraints."

Organizational rules often inhibit individual responsiveness and adaptability. Bureaucrats become cogs in the system. Their roles and functions are prescribed to them in the form of rules, regulations, and policies which leave very little room for independent decision making. "Clients who do not fit exact agency requirements for

either the substance of the service or its accessibility and availability often do not receive the benefits they need" (Slavin 1980, p.15).

Brubaker (1984, p.20) writes that another aspect of bureaucratic administration is that it is based on knowledge - specialized technical expertise. The social service system has indeed become increasingly specialized. Disabled individuals must now interact with different systems to have their needs met. Beeson (1983, p.242) points out that there are two types of functional specialization: categorical and administrative. He further writes that both categorical and administrative specialization are involved in meeting the needs of the mentally ill. Not only are there different categories of service and separate providers of care but meeting their needs can also cut across different categorical areas such as health, welfare, social security, vocational rehabilitation and so on. According to Beeson (1983, pp.244-245):

"Specialization that increases categorical and administrative subdivisions then also tends to promote standardization of response within those subdivisions. As a result, persons whose needs cut across categories of specialization and persons whose needs do not fit the modal client type within those categories are likely to be inappropriately served by the systems of care. Each agency's efforts to standardize its own plans, policies, and regulations leads to inflexible and narrow agency responses. These

responses may conflict each other and are rarely coordinated. Agency efforts to standardize response and advance its world views leads to proliferation of rules, regulations, and requirements across all relevant agencies. This undermines service delivery in three crucial ways. First, it drains away potential resources from service in order to fulfill administrative needs. Second, it makes a coordinated or holistic response virtually impossible. Third, it makes fitting individual needs to agency response a monumental task. In fact, much effort and time that could be spent providing services is spent instead trying to fit individuals into the system."

This discussion points out that bureaucracy as it is applied to the social service system is based on rules, however, those rules are often ambiguous. Secondly, it is based on knowledge, however, this has resulted in increased specialization which excludes many persons from services they need and makes services more difficult to access. Finally, calculable results can be obtained and methods of accountability for the purpose of efficiency appear to operate well, unless they are viewed from the perspective of the individuals trying to access the services.

#### SERVICES AVAILABLE

This section will describe what services are available to the homeless mentally ill and how they are accessed. Keep in mind that the individuals who are the subject of this paper are also suffering from symptoms of mental illness while trying to negotiate this system. They may be experiencing hallucinations, delusions, disorientation,



disorganized and/or racing thoughts as well as a myriad of other symptoms depending upon their diagnosis.

Beginning with the basics, there are several shelters in the metropolitan area where this writer has done her research. Many of the shelters are located near the downtown area. Each of the shelters is privately operated and has different rules or requirements for staying there. Meals are provided at many of the shelters for their guests. Several shelters provide meals for anyone who shows up. In addition, clothing pantries are provided by some local church organizations as well as some of the shelters. To access these services a person only needs to know where they are, be able to get there, be able to request the desired service, and be able to tolerate being around others. This may sound like a fairly simple task but it can be very difficult, especially for someone who is mentally ill. First of all, the shelters do not advertise themselves well for the most part so that they do not become the target of harassment. Thus, without a specific street address they can be difficult to find. Secondly, transportation can be a problem unless the individual is within walking distance or can somehow come up with bus fare. Finally, someone who is experiencing symptoms of mental illness may be unable to request services appropriately or unable to tolerate being around others.

In this context it becomes clear that meeting even these basic needs is not a simple task for this population, yet these are needs they must find a way to meet on a daily basis. It must also be noted that all of these services for food, clothing, and shelter are only intended and designed to meet needs on a temporary basis. In order to meet these needs on an ongoing or long-term basis one must turn to governmental social service agencies.

There are three levels of governmental agencies involved in administering various social service programs: 1) county, 2) state, and 3) federal. Each of these will be discussed separately.

#### COUNTY SERVICES

##### Financial Aid

At the county level there is a financial aid program called General Assistance (GA) which is based on need as determined by income. Once their General Assistance application is approved, an individual can move to an apartment where rent is \$225.00 a month or less with utilities included or move into another setting, such as a board and room, if a doctor has documented the need. The individual will also receive a fifteen dollar non-food voucher to purchase personal care or household items and is eligible for a clothing voucher of up to \$40.00 every six months. In order to purchase food, an application for food

stamps will have to be filed with the state department of social services. Furthermore, the individual will have to complete and submit a monthly report form where any changes in address or income are indicated, including income from selling blood plasma or aluminum can collecting. If income is reported, that amount is deducted from the rent assistance for the next month because it is expected that the income be applied to the rent. Provided that the requirements continue to be met each month, the individual will receive this assistance for approximately six months at which time re-application will be necessary.

To get an appointment to apply for GA can, at times, take up to five weeks and the appointment must be made by telephone. Furthermore, the individual cannot be more than fifteen minutes late for the appointment or it will be cancelled and will have to be rescheduled by phone. However, the interviewer can be more than fifteen minutes late and the individual is expected to wait as long as needed.

At the time of the appointment the individual who is applying must be able to provide some form of identification and able to answer the interviewer's questions, some of which require excellent memory skills. For example, one of the questions asked during the application process is to list all employers and dates of

employment for at least the last year. The same question is asked regarding previous addresses for the last year. For those who have been involved with day labor or who have been moving from shelter to shelter this can be an extremely difficult task.

Upon completion of the application the individual must also choose from a list of activities that he/she will be required to do unless he/she is determined to be disabled by a physician. The individual will then be given a list of items that must be provided to the GA worker within fifteen days. Often that list will include applications for any federal or state benefits that the individual may qualify for and the name and address of a landlord where the individual plans to reside if approved. Once this is accomplished the worker then has another fifteen days to decide whether or not to approve the application. Hence, it can take over two months from the time of the initial call to make the appointment for the person to receive any assistance and in the mean time he/she must continue to meet daily needs for shelter, food, and clothing.

#### Medical Services

The medical services program administered by the County is called Primary Health Care (PHC). Eligibility for this program is also determined by income. Individuals can apply for these services at the same time they file

their General Assistance application but one does not have to be on General Assistance to receive Primary Health Care benefits.

Through this program individuals can receive medical services at the Primary Health Care clinic. If the individual has medical needs that cannot be addressed at the clinic a written referral will be made to other providers. Emergency medical attention can be obtained at any hospital when needed as long as the provider contacts PHC by telephone for prior approval.

#### Mental Health Services

There are several hospitals in the area that provide inpatient and outpatient psychiatric services for the mentally ill, not to mention a variety of clinics that provide outpatient care. However, the responsibility of care for the indigent falls primarily on the County Hospital, whose inpatient beds are consistently filled and whose outpatient facility is overloaded with patients. The local County Hospital has 27 inpatient psychiatric beds. The County-operated Community Mental Health Center is also located within the hospital and provides outpatient services.

Persons receiving these services are scheduled appointments to see doctors in "med clinic" for medication checks and follow-up. In most cases, these appointments

last approximately 15 minutes and the doctor is a resident who is completing a rotation at the hospital and is being supervised by the hospital psychiatrist. Hence, persons receiving these services are often seen by different doctors each time the rotation changes. Although the actual time spent with the doctor is rather short, the wait to get in can be very long. It is not unusual for someone who arrived promptly at their appointment time to have to wait for over an hour to see a doctor.

Accessing these services initially can be time consuming as well. New patients must be seen by a social worker for an intake and screening appointment prior to being given an appointment to see a doctor. Exceptions are made in some crisis situations and the patient is seen by a doctor prior to screening but the patient will still need to complete the screening process to receive ongoing services. Inpatient services can be accessed in one of two ways: voluntary or involuntary. Either way, access depends on the availability of an open bed.

#### STATE SERVICES

##### Financial Aid

There are several social service programs that are administered by the State such as Aid to Dependent Children (ADC), Food Stamps, Medicaid, Aid to the Aged Blind and Disabled (AABD), State Disability, Title XX (for

transportation, day care, adult day care, and homemaker services). Eligibility for each of these programs is based upon need, income, and available resources. The application forms for the various programs tend to be several pages long and somewhat intimidating even to someone who is thinking clearly. For most of these entitlements a personal interview is also required to complete the application process, but will not be arranged until the application is received in the mail. Hence, this causes yet another delay. For the population being discussed here, however, eligibility for services such as AABD, Medicaid, and State Disability will depend upon the individual's eligibility for federal assistance programs such as Supplemental Security Income (SSI) and Social Security (SSA).

#### Medical Services

The State administers the Medicaid program which provides payment of inpatient and outpatient health services as well as prescriptions for those who are found to be eligible for the program. Eligibility is determined primarily by income guidelines and source of income. An individual who is on Medicaid can receive services from any provider who will accept Medicaid payment. Anyone receiving Medicaid services is assigned an Income Maintenance Worker who tracks the amount of income an

individual receives and reviews eligibility for State services such as Medicaid, Aid to the Aged Blind and Disabled, Food Stamps, Energy Assistance, etc. For those who receive some of the other services administered by the State, such as Title XX, they are also assigned a Service Worker who monitors need and eligibility for those services.

#### Mental Health Services

The State operates three Regional Centers that provide long-term inpatient psychiatric care. None of these centers is located within the metropolitan area that is the focus of this paper. Thus, individuals requiring long-term care are usually transferred to the Regional Center by the hospital currently providing inpatient care.

#### FEDERAL SERVICES

##### Financial Services

Through the Federal Government, individuals who are determined to be disabled are eligible for SSI and SSA benefits. To apply for these benefits a twelve page application form must be completed and submitted to the Social Security Administration. The form can be completed in person at the local Social Security office by appointment or on a walk-in basis. The form can also be completed by phone in certain circumstances or can be mailed for the individual to complete and return.



Appointments can be secured by calling an 800 number. One of the problems with this system is that the individual must have an address that correspondence can be sent to which is difficult for those who move from shelter to shelter and nearly impossible for those living on the streets. There have been recent efforts made by the Social Security Administration to alleviate this problem somewhat through the implementation of special phone numbers, cards indicating application dates given to individuals, and outreach efforts. Although it is too early to determine the success of these efforts, it is reasonable to suspect that follow-up will continue to be difficult given the mobility of the population.

Once the initial application is filed it is reviewed to determine whether or not the individual meets criteria to be determined disabled and unable to work. This can take several months. The individual is then notified by mail of the decision. If the decision is one of denial, the individual has sixty days to request a reconsideration of the application. This is done by completing more forms and submitting them. The file is then reviewed again and the individual may be asked to see a doctor for evaluation which is arranged and paid for by the Social Security Administration. If the application is denied at the reconsideration level, the individual has sixty days to

complete a request for a hearing before an Administrative Law Judge. It can take several months to get a hearing scheduled and, again, all notification is done by mail. The individual is usually encouraged to secure the services of a lawyer to represent them at the hearing where testimony is given and evidence reviewed. Throughout this process, the task is to prove that the individual is unable to do any job due to disability.

Once a favorable decision is received, the individual will be awarded benefits. The maximum payment allowed under SSI is \$407.00 per month. SSA benefits are based upon work history and can vary depending on quarters worked and amount paid in. However, if the Social Security Administration determines that an individual is unable to manage his/her own funds due to evidence received, it can require that a payee be appointed to manage their finances for them. In that case, no benefits will be paid until a payee is located. For the homeless mentally ill population it can be extremely difficult to find persons willing to be representative payees because they are usually isolated from family and friends, or don't have any.

#### Medical Services

The Federal Government administers the Medicare program. Through this program, disabled individuals who receive SSA payment can receive hospital and medical

insurance after 24 months of disability. Enrollment in the Medicare program is automatic at that time unless the individual specifies that he/she does not want coverage. Medicare does not pay for medication.

#### HOUSING

Once some means of paying rent has been established, permanent housing can be acquired. However, for the HMI population the lack of adequate affordable housing is not the only concern in attempting to establish residential stability. Many in this population need different levels of structured and supervised living situations if placement is to be successful. Availability of housing at these different levels is also lacking. Often, individuals must be placed on waiting lists for those that do exist, or there are none that provide the level of supervision that would best meet their needs. As a result, they meet with failure, or very limited success, in housing placements because they are inappropriate.

Currently in this metropolitan area there are two group homes for the mentally ill with a combined total of 23 beds available. There are two residential care facilities which provide 24-hour awake staff, and one domiciliary which is staffed 24 hours with sleeping facilities provided for the staff. There are several board and room facilities in the area that will accept the

mentally ill as residents although not all are licensed. The agency that employs the author also operates twenty-four apartments that are HUD subsidized which provide residential support staff to assist individuals with learning needed independent living skills. The only other option is to live in an independent apartment.

Even though the description of services here has been brief with many details omitted, one can clearly see that this is a complicated and confusing system for anyone to negotiate. It is doubly so for persons with impaired mental functions. After a discussion of the methods of research, the thesis takes up the difficulties persons faced in trying to negotiate this system.

### CHAPTER III

#### METHODS OF RESEARCH

As previously stated, the research question being asked in this study is: Does bureaucracy gets in its own way in attempting to meet the needs of the homeless mentally ill? In addressing this question, the study utilizes the participant-observation method of research and focuses on the following aspects of bureaucracy: 1) rules 2) accountability 3) specialization and 4) implementation.

Although the use of participant-observation methods and the agency's "contact sheets" are somewhat subjective and less quantitative in nature than some researchers would like, they have important advantages. For example, participant observation provides descriptions of problems that can be analyzed and used by policy-makers in recommendations for changes in programs. In addition, demographic data collected on contact sheets can provide a profile of the characteristics of the homeless mentally ill population in the given region. Demographic data are presented in this chapter, while case studies based on participant observation are presented and discussed in chapter 4.

According to Koegel (1988), efforts to understand the homeless people who live in our streets and shelters have

been numerous and helpful but have still left some gaps in our understanding of homelessness. While we have gained some knowledge of socio-demographic characteristics, rates of service utilization, and prevalence of chronic disorder, we know very little about how the homeless perceive their experiences or how they resolve crises they face. This lack of knowledge is somewhat related to the way we have pursued information regarding the population. To date, most studies have utilized structured interviews. Furthermore, Koegel (1988) notes that there has been an absence of qualitative approaches to the study of the homeless population.

Koegel (1988) explores three ways in which reliance on cross-sectional, quantitative studies have limited our understanding of homelessness: 1) The focus of attention has been on individual characteristics with very little attention paid to the ecology in which the homeless find themselves; 2) the research community's understanding of homelessness is based on static rather than processual perspectives; and 3) the behavior of homeless people has been looked at almost exclusively from an outsider's perspective rather than an insider's. Koegel (1988) makes a point that more ethnographic research is needed because behavior is most meaningfully understood when examined in context. Behavior depends upon the characteristics of the

person being observed, the setting he/she is in, and the individuals the person interacts with. According to Koegel (1988, p.1-10), focusing on individual characteristics alone can lead to misunderstandings of the phenomenon at hand because if one were to focus on the entire ecology of the situation instead, a very different picture may emerge.

The units of analysis used in this project are client/worker interactions. The various descriptions of the interaction between homeless mentally ill persons and service agencies were obtained by the author as a participant observer. As a case manager for HMI individuals in a nonprofit agency over the past three and one half years, I have been able to make sustained observations for this study. In that time I have had a total of 57 clients assigned to my case load. Aside from working with the homeless mentally ill on a full time basis, I have also attended several conferences and workshops that focused on the problems of the homeless mentally ill. I presented a workshop at the Mentally Ill Homeless Conference held in Ames, Iowa, April 13th & 14th, 1989. I was on the planning committee for the 1991 Training Conference for Providers of Homeless Services held in Omaha, Nebraska, on July 15th & 16th, and I served on the discussion panel at that conference. I also served on a panel for a workshop on Nebraska Programs for the Homeless

at the 1989 Family Conference held in Omaha, Nebraska, on July 27th-29th. In addition, I attend monthly meetings of the Omaha Coalition for the Homeless, where many issues are discussed among service providers.

As previously discussed, defining the population poses a major problem for researchers. Most of the studies done thus far have utilized different definitions, which makes generalization of findings impossible. There has been controversy over the issue of definition for quite some time and the controversy is likely to continue. The definition used in this study was developed by the agency that employs the author. Criteria were developed to operationalize the definition of the target population, the homeless mentally ill. These criteria included any individual who was age nineteen or older, had no permanent or stable place of residence, and met one or more of the following criteria:

- (1) Was diagnosed as having a major psychiatric disorder by a psychiatrist; or
- (2) Exhibited one of the following behavioral conditions of a major psychiatric disorder:
  - (a.) Disorganized thought processes.
  - (b.) Behavior out of situational context.
  - (c.) Behaviors dangerous to self.
  - (d.) Delusions or hallucinations.
  - (e.) Preoccupation with illogical ideas.
  - (f.) Behaviors dangerous to others.



(3) Reported history of psychiatric treatment more intensive than outpatient care more than once in his/her lifetime.

Before continuing, some explanation and description of the role of the outreach team and the case manager is in order so that the methods of data collection can be better understood.

The agency that employs the author and the outreach team is a nonprofit agency that provides psychosocial rehabilitation, vocational, residential, and case management services for individuals who are chronically mentally ill. One of the programs offered by this agency is homeless services which includes outreach and case management services. The function of the outreach team is to make contact with homeless individuals, targeting those who display behaviors indicative of mental illness, and offer to assist them in meeting their basic needs. This involves going to the shelters, streets, junkyards, abandoned buildings and other areas where homeless persons can be found and by then engaging the clients. For those individuals who do not show signs of probable mental illness, the team will make referrals to other helping agencies. For those who do show signs of probable mental illness, the team will not only make referrals, but will

also offer to assist the client in obtaining services by setting appointments, accompanying the client to those appointments, and acting as their advocate. This can include assistance with obtaining food, clothing, shelter, mental health services, housing, medical services, and financial entitlements. In most cases it takes more than one contact for clients to accept assistance with these services and can sometimes take several months for this to happen. In any case, the outreach team completes a "contact sheet" on a daily basis on each individual they talk to. This sheet, then, provides a physical description of the client and a summary of services provided.

In some cases the outreach team refers clients to case management services because the client needs extensive case management and follow-up services to obtain and maintain services. The case manager also acts as an advocate for the client and walks the client through the system as needed. The function of the case manager is to link, coordinate, and monitor services for the homeless mentally ill. In so doing, the case manager gets a firsthand view of the interactions of clients with various levels of different service organizations and how clients experience those interactions. The demographic data contained in this study were collected by outreach workers and the

author. The data were collected on contact sheets that were completed on a daily basis for each homeless individual contacted.

#### DEMOGRAPHIC FINDINGS

The purpose of this section is to provide a description of the observed characteristics, conditions, and needs of the HMI population in this metropolitan area.

As shown in Table I, the demographic profile of the homeless mentally ill population encountered by the outreach team indicates that the highest percentage are white males between the ages of 26 and 35. Since most of the referrals to the case management case load are made by the outreach team, this data is representative of the pool of participants used in this study. In comparison to the study done in Hennepin County, Minnesota by Kroll, Carey, Hagedorn, Firedog, and Benavides (1986, pp.283-286) which was discussed in chapter 1 of this paper, there are some differences in race; they report 60% white persons compared to 69.9% and they report 19% American Indian compared to 5.9% Native Americans reported in this study. As previously discussed, regional differences in demographics are not uncommon and are to be expected in this population.

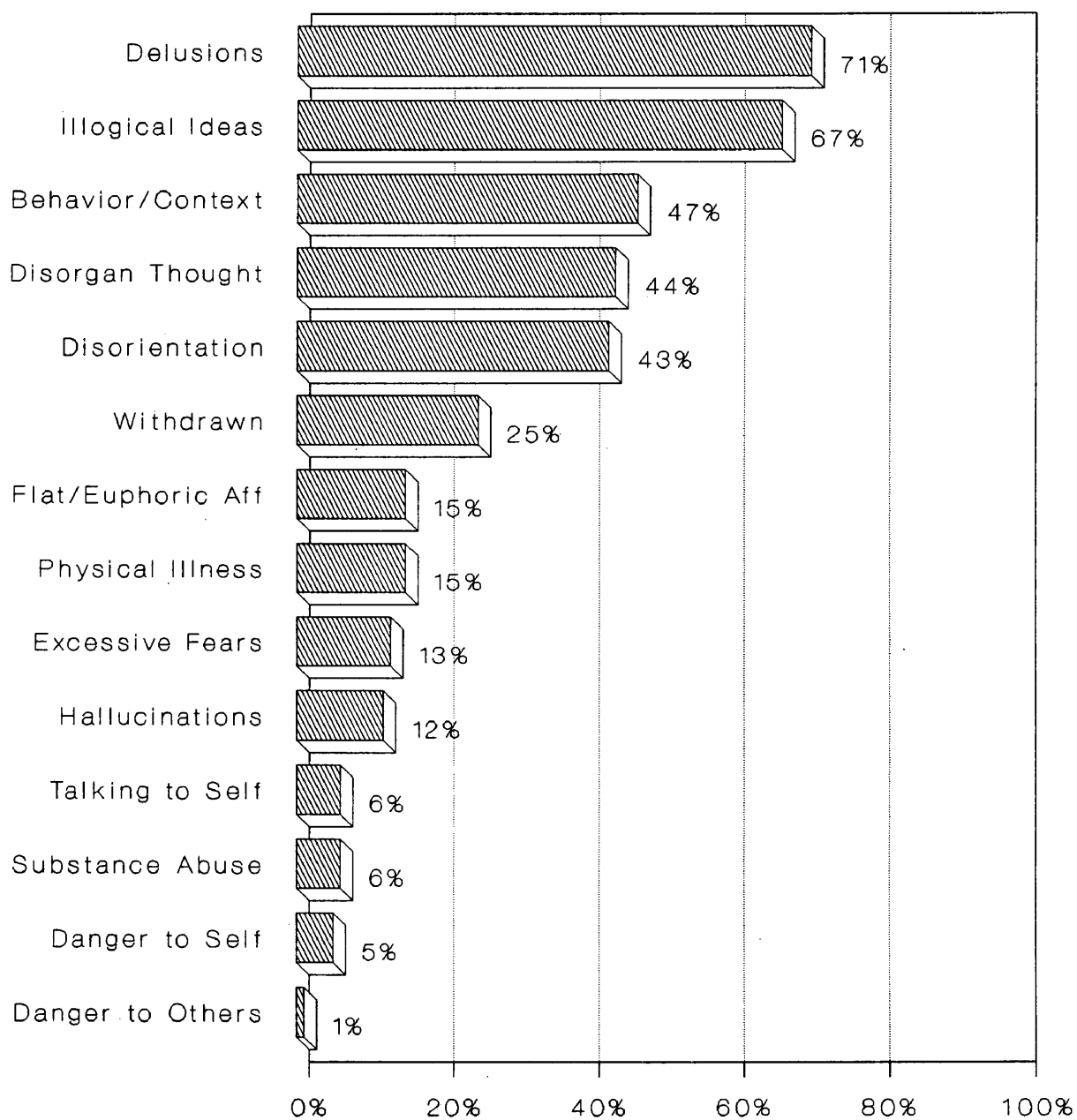
TABLE I  
Demographic Profile  
Homeless Mentally Ill Encountered  
September, 1986-August, 1990

		Homeless Mentally Ill Encountered	
		Number	Percent
GENDER:	Male	1032	75.0%
	Female	344	25.0%
RACE:	Black	274	19.9%
	White	962	69.9%
	Native American	81	5.9%
	Native Alaskan	1	0.1%
	Hispanic	38	2.8%
	Asian	4	0.3%
	Other/Unknown	6	0.4%
AGE:	18-25	215	15.6%
	26-35	525	38.2%
	36-45	358	26.0%
	46-55	171	12.4%
	56-65	86	6.3%
	65+	21	1.5%

(N=1376)

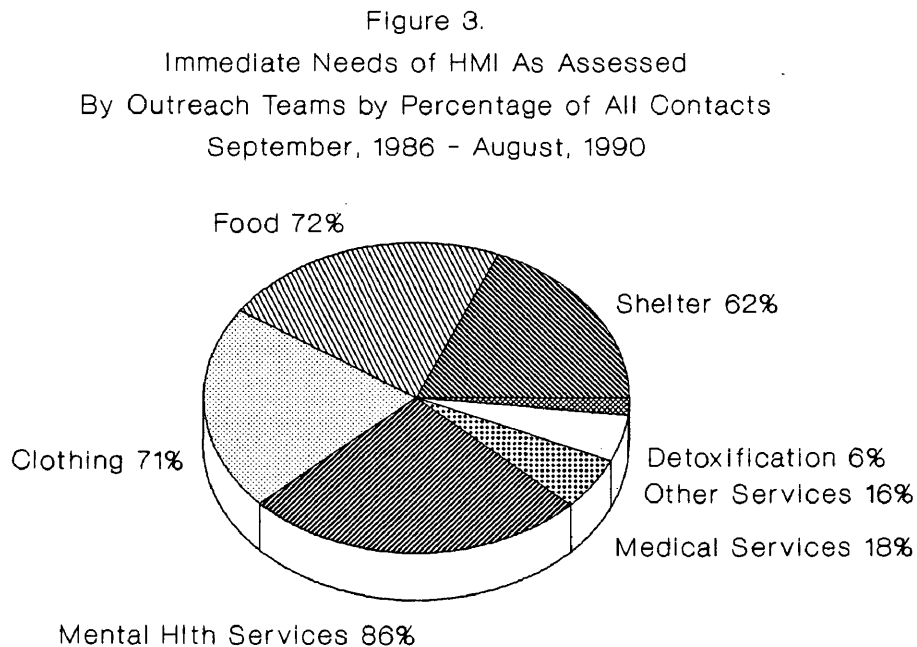
As indicated by Figure 2, the most prevalent conditions suggesting mental illness observed by the outreach team among the HMI population at the time of contact were (1) delusions; (2) illogical ideas; (3) behavior out of situational context; (4) disorganized thought processes; and (5) disorientation. Not only does this information add further to the description of characteristics of the HMI population studied, it also provides insight into their difficulty in accessing needed services.

FIGURE 2. Conditions Presented by HMI  
at Time of Contact By % of All Contacts  
September, 1986 - August, 1990



(N=10,192; Percentage exceeds 100% as individuals may present multiple conditions.)

Figure 3 shows immediate needs of HMI persons encountered as assessed by the outreach team at time of contact. The data here indicate that the immediate needs were predominantly related to basic survival concerns (food, clothing, shelter) and mental health services. Of course, this is not surprising given the situations the individuals are in. However, it is interesting that 10% more were in need of food (72%) than were in need of shelter (62%). While there is no explanation for this provided by the data, it is possible that these individuals were unsheltered and living on the streets or they were at risk of becoming homeless and in need of food.



(N=10,192; Percentage exceeds 100% as individuals may present multiple needs.)

Table II shows how many persons (n=20) were in need of entitlements, medical services, mental health services, and housing when they began working with the case manager. The table also shows how many of those persons were receiving the needed service upon admission and how many acquired the service during their admission to the agency with case management assistance. It is unknown whether or not those who were already receiving the services had help in accessing the services; however, the table clearly shows that many of the individuals needed case management assistance to acquire the services listed. The data in this table support the fact that these services are not as easily accessed as many might think they are.

The following data on services to the homeless mentally ill were collected by the agency that employs the author over a one year period, October 1st, 1989 to September 30th, 1990. It is included here to give some sense of the high needs of the homeless mentally ill population. During this time period, 43 individuals received case management services. The linking, coordinating, and monitoring of services for the homeless mentally ill was facilitated on 1,240 occasions. The acquisition of long term services such as mental health, income support, housing, and other social services was facilitated on 224 occasions. The acquisition of immediate

**TABLE II**  
**Matrix of Services Needed, Receiving, and Acquired**  
**for Homeless Mentally Ill**

	Needed	Receiving On Admission	Acquired During Admission
<b>ENTITLEMENTS</b>			
<i>Federal</i>	21	7	13
SSI/SSA	20	7	12
VA	1		1
<i>State</i>	47	11	33
AABD	17	3	11
ADC	2		2
Foodstamps	9	5	5
Title XX	19	3	15
<i>County</i>	8	1	5
GA	8	1	5
<b>MEDICAL SERVICES</b>			
<i>Federal</i>	6	3	3
Medicare	6	3	3
<i>State</i>	17	5	11
Medicaid	17	5	11
<i>County</i>	17	2	5
Primary Health Care	7	1	5
<b>MENTAL HEALTH SERVICES</b>	20	13	7
<b>HOUSING</b>	20	9	12

(n=20)

**Note:** Some individuals were receiving services when admitted and became in need of other services during admission. Also, individuals are often in need of, and eligible for, more than one service at the same time.



needs such as food, clothing, shelter, and medical services was facilitated on 310 occasions. In terms of outreach services, there were 2,432 contacts made with homeless mentally ill persons. The outreach team facilitated the acquisition of housing, income, mental health, and psychosocial services on 260 occasions. The maintenance of those services was facilitated on 1,040 occasions and the acquisition of immediate needs was facilitated on 600 occasions.

#### ETHICAL CONSIDERATIONS

One of the problems encountered in doing this type of research is that of ensuring the confidentiality of the persons being observed. It is essential in a study such as this that the identities of the subjects be protected, not only because of their right to privacy but also because of the stigma associated with both mental illness and homelessness.

For this reason, this author has utilized composite profiles of two individuals in some cases and fictitious data with regard to age, gender, and ethnicity where provided in observational descriptions. Furthermore, this author has chosen to keep everything anonymous, including the city in which I work, because this is a highly mobile population and these persons may be known to others in a variety of locations. Although the cases reported here

have been disguised, the situations described in chapter Four refer to actual observations of cases under my supervision.

## CHAPTER IV

### BUREAUCRATIC RESPONSES TO PUBLIC POLICY

#### CASE OBSERVATIONS

As stated in Chapter One, this project examines the role bureaucracy plays in the social problem of the homeless mentally ill. It asks the question; how is it that bureaucracy "gets in its own way" in attempting to meet the needs of the homeless mentally ill. This is a question that is best answered from the point of view of those who are attempting to get their needs met. This is a also question of process which is best addressed through the use of qualitative research methods rather than quantitative ones. The focus is not on how many homeless mentally ill persons there are or the circumstances that lead to their situation. The focus is on the bureaucratically administered service system and its difficulty in adequately meeting the needs of persons who are HMI.

Earlier chapters described the bureaucratic context of a variety of services that are available to meet the needs of persons who are homeless and mentally ill. This section describes the experiences of various individuals as they interacted with the bureaucratic service delivery system. As previously mentioned, these observations were collected

by the author. The observations made by the author will be divided into sections corresponding to the aspects of bureaucracy that were discussed in Chapter Two: rules, implementation, accountability and specialization.

## RULES

### Case 1

One of the persons the author worked with had been located in a local shelter by the outreach team. This individual was a white woman in her early forties. She had moved here from another city and was receiving SSI. In working with her it was discovered that she had moved several times because she believed that she was being followed and threatened by her ex-husband. Three appointments were made for her to apply for Medicaid and AABD benefits at the State Social Services office but each time she did not go because she was afraid her location would become known to her ex-husband. She finally agreed to go to the appointment the fourth time it was scheduled. During the interview, she became upset when the interviewer asked about her marital status. The interviewer contended that the application could not be completed nor reviewed without that information being given during the interview. The interviewer also refused to accept this information from anyone other than the client even though the interviewer understood that the client was mentally ill and

delusional. The client left the interview and shortly thereafter, left town. If the interviewer had been able to allow for a little flexibility in the rules perhaps this person could have achieved some stability in her life.

## Case 2

Another person that the author had been working with for some time was initially contacted by the outreach team in the lobby of a local insurance agency. Someone from the agency had called and reported that this woman who appeared to be in her 30's had walked into their lobby and was very upset. After meeting with her, the team transported her to the county hospital because she appeared to be hallucinating and was very agitated. In talking with her, the team had also learned that she came to Omaha on a bus from Montana and that she was homeless. They also discovered that she had a bachelor's degree.

The woman was hospitalized for a few weeks and was referred to a board and room upon discharge. The board and room setting was recommended by the psychiatrist because the woman tended to hallucinate more when alone, had difficulty completing daily tasks such as cooking due to severe anxiety, and she also had a substance abuse problem in addition to her mental illness which was more difficult for her to cope with when living alone. The woman moved into a board and room and began receiving GA. She had

applied for SSI and state benefits all of which were pending decision.

She received notice from GA that she needed to make an appointment with them to re-apply as her six month continuance had ended. She did so and she went to the appointment as scheduled. She sent in all requested paperwork with the exception of the doctor's statement of disability. She had given this statement to the mental health clinic she attended in order to have it completed and returned. Her GA worker called her case manager upon receiving the statement from the doctor and reported that the doctor did not indicate that a board and room situation was needed in this case and the client would have to move to an apartment. Upon hearing this, the client responded "I'll just go back to the Open Door Mission. I can't live in an apartment". The woman knew she could not yet cope with living alone without decompensating and she was so fearful of this that she would prefer being homeless and living in a shelter to living alone in her own apartment. With intervention by the case manager, the error was rectified and she was allowed to remain in her board and room. However, if she had not had someone available to assist her and intervene in this situation she would probably have moved back to the shelters. Again, if the GA worker had been able to allow for some flexibility in the

rules a simple telephone call to the doctor could have taken care of the problem very quickly.

#### Case 3

In another situation an individual that has been working with the outreach team for over two years was finally approved for SSI. He prefers sleeping on the streets and seeks shelter only in the most extreme weather conditions. This person is a white male in his late thirties who believes that people follow him around and hit him in the legs and back when he is trying to sleep. He continually refuses to see any doctors and is reluctant to talk to anyone.

When his SSI was approved it was also determined by the Social Security Administration that he was in need of payee services and a volunteer payee was found. The client refuses payee services and Social Security rules say he must be aware of payee services and accept the person assigned as payee. In the meantime, he continues to live on the streets, even though he has thousands of dollars in back pay accruing at Social Security.

#### IMPLEMENTATION

#### Case 4

In another case, an individual the author worked with went to apply for AABD and Medicaid benefits and he was extremely uncomfortable with providing information about

himself due to paranoia and a belief that he was being used in a governmental experiment. This individual spoke with a different interviewer than the person in case 1. This interviewer, unlike the first, readily accepted information from the case manager when the individual was uncomfortable providing it. The interviewers either interpreted policy differently or else exercised discretion. In either case, the two interviewers implemented the policy differently based upon their interpretations.

#### Case 5

Implementation also became a problem when the state social service agency changed its policy regarding utilization of transportation providers. In attempting to coordinate policy changes it became clear that each service worker implemented the policy differently. For example, in one case the worker told a client that he would no longer be able to utilize cab service as he had been doing and transferred the transportation services to a private provider. Another worker told a different client that her cab service could continue because she had been using the cabs prior to the change and they just weren't writing any new cab orders. Needless to say, it was very difficult to make sense of this to clients who were being told different things and who already had increased difficulty making sense of their world due to symptoms of mental illness.



## ACCOUNTABILITY

### Case 6

Another individual had been doubling up with friends and family for a time but his behavior was such that he was always asked to leave. This person was a black male in his late twenties who tended to get into fights because he had difficulty communicating with others without being perceived as being insulting. He began staying in shelters and had made a GA appointment. While waiting for his appointment date his behavior continued to get him into trouble and finally reached the point that he could not go to any of the shelters. In his frustration one day he became tearful and said "why does this have to take so long? Don't they know I have no place to go?" He slept under bridges until his GA was finally approved because the GA worker was unable to speed up the application review at the risk of making an error for which he would be accountable.

### Case 7

The individual in this case was a white male in his early thirties whose symptoms of mental illness included severe obsessive-compulsive behaviors. The outreach team and this writer had worked with this individual for over a year just to move him out of the shelter and into a board and room. Completing simple tasks was extremely time

consuming for this man because he had to re-check everything he did several times. For example, it often took him two days to prepare to take a shower and it took several hours to tie one shoe. With the assistance of the outreach team and this writer, he had applied and been approved for SSI and had received his first check.

In order to open a bank account or to cash his check he needed a current picture ID. In order to purchase the identification he needed to cash his check but of course he could not do so without a picture ID. The case manager had to access money from a charitable organization to purchase the identification. It is clear that the rules requiring current picture identification in order to cash checks are made for the purpose of accountability but it often creates a barrier for those who don't have the funds to purchase it in the first place.

#### Case 8

Another person had been working with the outreach team and the author for quite some time and finally agreed to accept help in getting GA. She had been living in the shelters for a long time and her behavior was bizarre although not threatening or dangerous. She would often talk, laugh, and sing to herself. At times she would be completely unresponsive when spoken to. She made it to her GA appointment with assistance from the case manager and

was approved once the paperwork process was completed. She needed constant reminders to send in her monthly report form on time. One month she thought she had sent in the form but she had not and she was terminated from GA services. Her rent had to be gathered from a variety of charitable organizations until she could get to GA to reapply. Her GA worker had been aware of her forgetfulness and knew that it was probably related to her mental illness but could not accept the form late because of the rules. Furthermore, the worker is held accountable for whatever eligibility determinations he/she makes and, without the form, the worker had no measurable way of determining ongoing eligibility.

#### SPECIALIZATION

##### Case 9

One individual the author worked with was a severe diabetic, in addition to being mentally ill, and was not following through with recommended medical treatment or medications. This person was also under Board of Mental Health Commitment (BOMH) and he received both his medical and mental health treatment at the local County hospital. He was also abusing alcohol, and the medical doctor expressed extreme concern, to the point of indicating that the person was a danger to himself. The medical doctor had not communicated this concern to the mental health clinic

staff or doctor until the case manager intervened and learned that the medical doctor had not been aware that the person was under BOMH. Clearly, specialization became a problem in this case as the specialists within the same hospital did not communicate between themselves regarding this person's care.

#### Case 10

In this case the individual is a black male in his early thirties whose primary diagnosis was mental retardation. He frequented area shelters and was easily victimized by others, often getting beat-up. Extensive efforts to get appropriate supportive services for him failed due to long waiting lists and funding problems in the MR system. Due to his high need for assistance, a psychiatrist changed his primary diagnosis to a mental illness simply so that he could receive care under one system that another system was unable to provide at the time.

This is especially troubling for those who are dually diagnosed because the systems themselves are specialized. A person with a primary diagnosis of mental retardation cannot receive services from a mental health agency even though he may also have a diagnosed mental illness. The mental illness diagnosis must be listed as the primary diagnosis in order for the person to receive services from

mental health agencies such as the one that employs the author.

Some of the responses to the bureaucratic service system are repeated by different individuals. Their frustration, confusion, and anger can be frequently observed when one walks through the system with them. Comments like, "What's the point, it won't help me today"; "What'll I do until then?"; "Why can't I go into the hospital if I know I need to?"; and "Why does getting help have to be so confusing? I have enough problems already," can be heard over and over again.

## CHAPTER V

### DISCUSSION/CONCLUSIONS

The cases provided here clearly show that rules, accountability, specialization, and implementation created barriers to meeting the needs of the homeless mentally ill population. Furthermore, calculability creates funding problems because, as pointed out earlier, this population has yet to be accurately counted. Agencies do attempt to meet the needs of the HMI population by providing services aimed at assisting them. However, as shown here, the administration of these services through bureaucratic means also creates barriers to those services for many of the individuals who are in need of them.

The homeless mentally ill face a highly bureaucratized and complex system. Many of these systems do not feature adequate linkage and certainly they are not flexible. The information and observed interactions presented here show that services are fragmented, inflexible, and uncoordinated. Those homeless mentally ill individuals who need help the most are denied access to care and services because of the nature of this complex and interwoven system. Simply put, the client should not be forced to fit the program; rather, the program should be developed to fit the client. Requiring homeless mentally ill clients to

behave in preconceived ways, no doubt, is a fruitless exercise. Services need to reflect the fact that the homeless mentally ill are indeed mentally ill. Rules may need to be bent. Exceptions may need to be made. Overall, flexibility is a concept that must be present if the needs of the homeless mentally ill are to be met.

Effective treatment and rehabilitation of the homeless mentally ill are complex issues. This population is diverse and their needs are many. They have an overwhelming set of social and mental health problems. Their life-style presents problems and expenses for society and challenges us to find satisfactory solutions. Given the multifaceted nature of their many needs it is unlikely that the mental health system alone will be able to provide solutions. It would be more effective to combine mental health, housing, and social services and provide them in a single coordinated setting. Furthermore, aggressive case management and outreach services are necessary components to provide coordination of services and to advocate for individuals as they negotiate the system.

The problem of the homeless mentally ill in our society is truly a social problem. Bureaucracy is central to this problem. Due to its bureaucratic nature, our service delivery system poses barriers between services it provides and those who need them. The problem here is not

one of a large group of individuals who do not wish to change their situation or who belong in institutions. The problem is one of an inflexible system that is made up of formal rules, specialization, and the need for calculable efficiency. The problem is a social one. The problem is bureaucracy.

There is a discrepancy between the needs of the homeless mentally ill and what is provided to meet those needs. The data presented here and the various studies reviewed all point to the need for flexibility and integration of services to meet the needs of the homeless mentally ill. What is offered is a system of services that is fragmented, rigid, complex, and uncoordinated. Bureaucracy is at the heart of the discrepancy. It is unlikely that the bureaucratic form of administration will be reformed or replaced any time soon, however, the first step is recognizing that it is problematic in many ways. Perhaps this recognition will occur as the economic feasibility of this form of administration becomes more questionable.

It is clear that interactions between the homeless mentally ill and systems of service are burdensome to say the least. Due to its complex and inflexible manner, the traditional bureaucratic service delivery system falls short of meeting the needs of this population. Though the



barriers are many and the challenge of reform is not easy, changes are realistic. A higher level of knowledge about the homeless mentally ill, more coordination, proactive leadership, and innovation in the service delivery system are essential to adequately address the complex and growing problem of homelessness amongst the mentally ill.

#### CONCLUSIONS

No matter how many homeless mentally ill persons there are or what circumstances lead them into their situation, the bureaucratic service system as it is now is maladaptive to meeting their needs. While this system may work for some persons it does not work for the homeless mentally ill population. The current system which is very specialized, hierarchical and bound by rules poses barriers to meeting the needs of the HMI population.

Although this system may make very rational sense to policy-makers, it makes very little sense to those HMI persons who are trying to access the services they need. It must be remembered that these are individuals who are trying to cope with a mental illness while they struggle daily to meet their basic needs. They have different priorities than most of us. They don't have easy access to transportation or telephones. Furthermore, they must cope daily with the stigma of being homeless and the stigma of being mentally ill.

It is unlikely that the current system will ever be able to adequately address the needs of HMI persons. An integrated and flexible service system is needed to adequately serve this population and these are aspects which simply cannot be found within bureaucracy.

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